Psychiatric Morbidity among Residents of a Destitute Rehabilitation Centre in Lagos, South-western Nigeria

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ABSTRACT

Background. *Destitution is a global problem. Previous studies indicated that the association between destitution and mental illness is a public health concern. Publications on destitute rehabilitation centres are scanty in Africa. This study aimed at determining the psychiatric morbidity and associated sociodemographic correlates among the residents of a destitute rehabilitation centre in Lagos, South-western Nigeria.*

Method. *The residents of a destitute rehabilitation centre were investigated for psychiatric morbidity. They were interviewed one-on-one basis using the ICD-10 diagnostic criteria for presence of specific mental illness by a consultant psychiatrist.*

Results. *The majority of the participants 400 (94.7%) were unemployed, single 187 (44.3%) and 353 (83.6%) lived on the streets. Among the participants, 137 (32%) were diagnosed with schizophrenia, 89 (32.4%), mental and behavioural disorders due to alcohol and multiple substance abuse, 51 (12.1%), antisocial personality disorder, 13 (7.1%) mania and (1.8%) had severe depression The association of drug use between males and females were found to be statistically significant (p=0.005).*

Conclusion. *Residents of the investigated destitute rehabilitation centre had high prevalence of mental illness. Interventions focusing on risk factors for destitution such as severe mental illness and substance use disorders should be looked into by policy makers. Mental healthcare service should also be provided in Nigerian destitute rehabilitation centres to reduce incidence and prevalence of mental disorders.*

Keywords: *Destitute, psychiatric morbidity, rehabilitation centre; Lagos, Nigeria*

INTRODUCTION

Destitution is a major global public health concern.[1-4] Destitution is reported to be on the increase not only in major cities of the developed countries but also developing countries.[1-4] A destitute can be referred to as someone who experiences extreme poverty, social deprivation, devoid of any asset, and also marginalized socially.[5-6] Due to the impoverished status of the destitute, they were unable to sustain basic minimum personal or social needs.[1-4] In this regard, they become dependent on the general public and sometimes government for their daily livelihood.[1-6]

The aetiological factors for destitution include: domestic violence, unemployment, poverty, unaffordable housing (especially in major cities), natural disasters, alcohol and substance abuse, deinstitutionalization, migration, former prisoners, being disabled and individuals suffering from chronic mental illness.[6-10]

The destitute population includes vagrants, beggars, street urchins, sex workers, those recently released from prisons, people with chronic severe mentally illness, elderly people with dementia, street children, persons with disability and migrants.[3-4,10-12] These set of people are frequently exposed to various types of dangers. In this light, the destitute repeatedly experience infections, rape, sexually transmitted illnesses, sexual abuse, prostitution, drug and human trafficking, crime, police harassments, violent assaults, reduced quality life and untimely deaths.[3-4,6-8,10-13] Therefore, when the destitute frequently experience physical or emotional trauma, it could precipitate mental disorders such as anxiety, panic, phobia depression and posttraumatic stress disorders.[13-16] For this reason, the prevalence of mental disorders among the destitute was reported to range from 2% to 90%.[3-4,9] Despite reported high prevalence of physical and mental illnesses in these groups of people, they do not have access or use medical facilities.[3-4,9,10,12]

There is a paucity of literature regarding psychiatric morbidity and its prevalence among Nigerian destitute population. In view of the widespread presence of destitution in Lagos, Nigeria, we set out to explore the psychiatric morbidity and associated sociodemographic correlates among residents of a destitute rehabilitation centre in Lagos, Nigeria.

MATERIALS AND METHODS

Study design and Setting

This study was a cross-sectional one. It took place at a destitute rehabilitation centre in Ikorodu, Lagos, Nigeria. The destitute rehabilitation centre was established in 1977 with the sole aim of providing shelter and possible rehabilitation for the destitute in Lagos State. The centre houses six hundred and twenty-four persons is managed and supervised by Lagos State Ministry of Social Welfare. It is headed by a social worker. The staff of the centre comprises social workers, registered nurses, medical officers and a consultant psychiatrist. It also has a skill acquisition unit where destitute without any vocation can acquire vocational skills. The data collection took place between January and March 2015.

Ethical clearance

The permission to carry out the study was taken from the relevant authorities of the Lagos State Ministry of Social Welfare. Written and verbal permission were also sought from every participant that took part in this study.

Measures

A semi-structured questionnaire was used to collect sociodemographic details of the participants which included, age, gender, marital status, educational level, employment status, length of stay, how they arrived at the centre, religion, state of origin, comorbid physical illness, and whether the participant has a relation in Lagos.

Clinical variables

The mental status of each participant was evaluated by a psychiatrist and psychiatric disorders were diagnosed using International Classification of Disorders-10, (ICD-10) diagnostic criteria.[17]

Data Analysis

The data collected was analysed with the IBM-Statistical Package for Social Science (IBM-SPSS–version 24). The results were expressed as mean ± standard deviation (SD) or frequency (%). Chi–Square was used to analyse the associations between the socio demographic variables and psychopathology. P value <0.05 was considered significant.

Results

The findings of this study showed that majority of the participants 254 (60.2%) were females and 168 (39.8%) males, ratio1:1.5, most of them had primary 116 (27.5%) and 184 (43.6%) secondary education completed, only 53 (12.5%) had tertiary education. A large preponderance of the participants 400 (94.7%) were unemployed. There were more single 187 (44.3%) participants than married participants 157 (37.2%). Majority of the participants 353 (83.6%) were removed from the streets of Lagos and 55 (13.1%) were brought by family members due to severe chronic mental illness as reflected in Table1.

Three hundred and nine of the respondents (73.2%) had mental illness. Among those with mental illness, 137 (32%) had schizophrenia, 89 (21.1%) mental and behavioural disorders due to alcohol and multiple substance abuse, 51 (12.1%), antisocial personality disorder, 13 (7.1%) mania and (1.8%) severe depression as shown in Table 2.

Some of the participants also had physical illnesses such as scabies, multiple body injuries, HIV/AIDS, tuberculosis, asthma and inguinal hernia as shown in Table 2. The comparative statistical analysis showed that more women were diagnosed with schizophrenia, mania and depression. However, more males abused alcohol and psychoactive substance than the female participants. Only the association of drug use between males and females were found to be statistically significant (p=0.005)

Table 1: Sociodemographic characteristics of the participants

Characteristics	Frequency (n=422)	Per cent (%)
Sex		
Male	168	39.8%
Female	254	60.2
Educational Status		
None	69	16.4
Primary school	116	27.5
Secondary school	184	43.6
Tertiary institution	53	12.5
Employment status		
Students	10	2.3
Unemployed	400	94.7
Employed	8	1.8
Pensioner	4	0.94
Marital status		
Single	187	44.3
Married	157	37.2
Divorced/separated	68	16.1
Widow/widower	10	2.3
Pathway to care		
Brought by family	55	13.1
Brought by institutions	11	2.6
Rescued from the street	353	83.6
Referred form hospital	3	0.71

Table 2. Mental and physical health morbidity of the participants

Diagnosis	Frequency (n=422)	Per cent (%)
Mental Health Disorders		
No mental health disorder	113	26.7
Schizophrenia	137	32.4
Alcohol/substance abuse	89	21.2
Antisocial personality disorder	51	12.1
Mania	13	3.10
Depression	8	1.82
Seizure disorder	6	1.42
Mental retardation	5	1.18
Physical health disorder		
None	371	87.9
Scabies	37	8.7
Multiple body injuries	7	1.65
HIV/AIDS	2	0.5
Tuberculosis	2	0.5
Asthma	2	0.5
Hernia	1	0.2

Table 3. Association between the psychiatric diagnoses and gender of the participants

Variable	Male n (%)	Female n (%)	p value
Schizophrenia	51 (12.1)	86 (20.4)	0.452
MBD due to Substance use	54 (12.8)	51 (12.1)	0.005
Mania	6 (1.4)	7 (1.7)	0.635
Depression	3 (0.7)	5 (1.2)	0.893
Seizure Disorder	3 (0.7)	3 (0.7)	0.608
Mental Retardation	1 (0.2)	4 (0.9)	0.363
Antisocial Personality Disorder	17 (4)	34 (8.1)	0.314
Schizophrenia /MBD due to substance use	33 (7.8)	64 (15.2)	0.184

DISCUSSION

The findings of this study also showed that 73.2% of the participants had various psychiatric disorders. These results are in consonance with reports from other studies. Previous studies showed that mental disorders ranged between 2% and 90% among the destitute population.[1-6,10-12] Majority of the destitute were females. The probable reasons why there were more females in this study could be due to the possibility of the males absconding from the centre to return to the streets to continue with their beggar status or possibly continue with the use or abuse psychoactive substances. The female destitute residents might also have been domesticated in the centre. A large proportion, four-fifths of the respondents completed primary or secondary education. Studies have shown that individuals with limited education and in a state of unemployment are predisposed to poverty, major risk factor for destitution.[13,15,19,20]

The psychiatric disorders prevalent in our study were schizophrenia, mental and behavioural disorders due to alcohol and multiple substance abuse, antisocial personality disorder, mania, depression, seizure disorders and mental retardation. These were also in keeping with findings from previous studies.[13,15,19] Alcohol and substance abuse were also found to be associated with destitution.[3,8,10,12] Other studies have also shown strong relationships between destitution and substance abuse disorders.[3,8,10,12]

The results of this study also showed that one quarter of the participants had physical illnesses. The observed physical illnesses were scabies, tuberculosis, HIV/AIDS, multiple body injuries, and asthma. The presence of these physical illnesses could be due to the long-term exposure to disease agents, living in overcrowded unsanitary conditions and poor feeding habits. Similarly, destitute do not relatively have access to medical facilities when taken ill, therefore, comorbid conditions between mental disorders and physical illnesses could be common among them.

A large proportion of the participants (83.6%) were removed from the streets as homeless destitute. At the period of their removal, most of them were beggars, destitute, vagrants, and the chronically mentally-ill. Published scientific studies indicated that those who eventually end up in sheltered centres were the homeless, vagrants, beggars, street urchins with addiction problems, individuals with previous history of incarceration, released prisoners, and people with chronic severe mental illness.[4,7,12,20-22]

Almost all the participants were unemployed pre-admission to the centre. Again, previous studies indicated that unemployment was a major risk factor for poverty, and poverty could put vulnerable individuals at risk factor for the development of mental illness, destitution and homelessness.[4,7,12,20-24] Therefore, it may be inferred that unemployed individuals with mental illness; without adequate family and social support may not be able to afford the reasonable good housing standards that comes with living in the cities.

One of the major reported reasons for the high rates of psychiatric disorders in sheltered homes was due to the deinstitutionalization movements in Europe and USA where large numbers of the mentally ill were discharged back to the society.[10,12,18,20] However, that may not be the case in Nigeria. What obtains in Nigeria and other developing countries is trans-institutionalization where large number individuals with severe mental illness are shifted from psychiatric hospitals, to prisons and ultimately to rehabilitation centres for the destitute.[15,21-13]

We recommend that the Lagos State government make mental healthcare available to every citizen of Lagos State by integrating mental healthcare services into primary care; reduce identifiable risk factors for homelessness such as programmes for the prevention of mental illness, drug addiction and to also provide adequate mental health services in destitute rehabilitation centres.

Our study was limited by its cross-sectional nature and as such, generalization of its findings to the wider population may not be feasible. However, future prospective and longitudinal studies involving other rehabilitation centres for the destitute would provide more detailed and reliable information on the physical and mental health conditions of these groups of people.

CONCLUSION

This demonstrated a high prevalence of mental illness among the participants of a destitute rehabilitation centre. Interventions focusing on potentially modifiable factors such as severe mental illness and substance

use disorders should be looked into by policy makers. Mental healthcare service should also be provided in Nigerian rehabilitation centres because homelessness is a now a very serious public health concern.

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